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# PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, February 25, 2003, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Commissioner Christine C. Ferguson, Chair, Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Ms. Shane Kearney Masaschi, Ms. Maureen Pompeo, Mr. Albert Sherman, Ms. Janet Slemenda, Dr. Thomas Sterne, and Dr. Martin Williams. Attorney Donna Levin was present as General Counsel.

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Chairman Ferguson announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½.

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The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Paul Dreyer, Director, Division of Health Care Quality; Ms. Nancy Ridley, Assistant Commissioner, Bureau of Health Quality Management; Mr. Howard Wensley, Director, Office of Community Sanitation; Ms. Joyce James, Director, Determination of Need Program; and Attorney Tracy Miller, Deputy General Counsel, Office of the General Counsel.

## RECORDS OF THE PUBLIC HEALTH COUNCIL:

Records of the Public Health Council Meeting of October 29, 2002 was presented to the Council. After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve Records of the Public Health Council Meeting of October 29, 2002.

## PERSONNEL ACTIONS:

In a letter dated February 10, 2003, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the reappointment of Walter Levitsky, M.D. to the medical staff of Tewksbury Hospital. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the reappointment of

Walter Levitsky, M.D. to the medical staff of Tewksbury Hospital be approved for a period of two years beginning February 1, 2003 to February 1, 2005:

| **REAPPOINTMENT** | **STATUS/SPECIALTY** | **MEDICAL LICENSE NO.** |
|---|---|---|
| Walter Levitsky, M.D. | Active Staff/ Internal Medicine/Consultant Staff of Neurology | 26773 |

In a letter dated February 10, 2003, Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of initial appointments and reappointments to the various medical and allied health professional staffs of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the initial appointments and reappointments to the various medical staffs of Lemuel Shattuck Hospital be approved as follows:

| **APPOINTMENT** | **STATUS/SPECIALTY** | **MEDICAL LICENSE NO.** |
|---|---|---|
| Daniel Weiner, M.D. | Consultant /Internal Medicine | 213380 |
| Yvette Westlake, M.D. | Consultant/Psychiatry | 202601 |

| **ALLIED HEALTH PROFESSIONALS APPOINTMENTS** | **STATUS/SPECIALTY** | **MEDICAL LICENSE NO.** |
|---|---|---|
| Teresa Margate, N.P. | Allied Health Professional | 191582 |
| William McCarthy, CNS | Allied Health Professional | 108098 |

| **REAPPOINTMENTS** | **STATUS/SPECIALTY** | **MEDICAL LICENSE NO.** |
|---|---|---|
| Barbara McGovern, M.D. | Active/Infectious Diseases | 74283 |
| Benjamin Smith, M.D. | Active/Medicine/GI | 76962 |
| Marie Turner, M.D. | Active/Medicine/Pulmonary | 45947 |
| Muhammed, Absar, M.D. | Active/Psychiatry | 152608 |
| David Cherniak, M.D. | Consultant/Radiology | 159590 |
| Carla Ross, M.D. | Consultant/Radiology | 79076 |
| Marianne Hughes, D.M.D. | Consultant/Dentistry | 18484 |
| Steven Schwaitzberg, M.D. | Consultant/General Surgery | 55759 |
| Bonnie Zimble, D.M.D. | Consultant/Dentistry | 17907 |
| Gloria Shapiro, CNS | Allied Health Professional | 100851 |

In a letter dated February 5, 2003, Blake M. Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of the reappointments of physicians to the affiliate medical staff of Western Massachusetts Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointments to the active and consulting medical staff of Western Massachusetts Hospital be approved:

| **REAPPOINTMENTS** | **STATUS/SPECIALTY** | **MEDICAL LICENSE NO.** |
|---|---|---|
| Rodney Larsen, M.D. | Internal Medicine | 38727 |
| William Dean, III, M.D. | Neurology | 75273 |
| Edward Walsh, OD | Optometry | 1828 |

In a memorandum, dated February 5, 2003, Christine Ferguson, Commissioner, Dept. of Public Health, recommended approval of the appointment of Ian A. Lang to Administrator VI (Chief of Staff), Commissioner's Office. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Ian Lang to Administrator VI (Chief of Staff), Commissioner's Office, be approved.

**STAFF PRESENTATION:**

**AMBULANCE DIVERSION: UPDATE ON CURRENT STATUS", BY Dr. Paul Dreyer, Director, Division of Health Care Quality:**

Dr. Paul Dreyer, Director, Division of Health Care Quality, made the Ambulance Diversion presentation to the Council. He said in part, "…What I am going to talk about is the current status in Massachusetts of the Ambulance Diversion System situation…Diversion occurs when a hospital closes itself down to ambulance traffic because the hospital can't provide timely care. This results in two phenomena. First of all, you haven't got ambulances driving around the state with no place to go. There is a delay in ambulances getting to where they want to be, the nearest hospital. But the other, less obvious cause of diversion may be in response to boarding, which is a phenomenon of patients who are ready to be admitted to a hospital who need an inpatient bed. The scenario often is that a hospital ED will have many patients boarding and so they will be unable to take care of the next patient that might come by and that will cause ambulance diversion. The diversion may be a symptom of the hospital system reaching capacity. Here is the situation thus far. We tracked data by EMS regions. Diversion happens most frequently in Regions 3 and 4, so I am going to focus on those regions. Region 3, which is North Shore/Merrimack Valley, has been collecting data on them since 1998…Each year the problem has gotten worse. There is a seasonal effect. It is typically worse in the winter, but what has been worrisome this particular year, what you see in 2001, you had this August phenomenon where it was

high. Historically from 1998 to 2001, the problem got worse, almost some would say, catastrophic. Region 4 has been collecting data for two years and you can see a marked increase in 2001 over 2000. Again, the seasonal effect. Region 3 diversion hours increased 610 in 1998 to 3579 in 2001. That's a 600 percent increase. In region 4, in the last two years, , it almost doubled." Dr. Dreyer quoted a physician, "While increasing use of the Emergency Department, especially for non-urgent needs, causes significant problems in patient flow, staff burn-out, and ED operations, we do not think that it is those who seek care for non-urgent issues who are responsible for the recent crisis of ambulance diversions. It is really the acutely ill patient who is waiting in the ED for a hospital bed who creates the bottleneck that leads to overcrowding, diversions, and essentially a breakdown in the entire system" Dr. Dreyer continued, "This point has been associated with some controversy for years. When diversion first came onto people's radar screens, there was a lot of concern about people using Emergency Departments for primary care, and that phenomenon has in fact been increasing and it is a problem that people were trying to use to inflate the two issues. They are really two separate issues. There is undoubtedly a problem with patients coming to the Emergency Department for primary care, and that number has been increasing and it has been resulting in queues and it has consequences for the system. But that is not what is causing ambulance diversion. What is causing ambulance diversion is very sick patients who are coming in to the ER, who can't get access to a bed because the beds are full.

Dr. Dreyer stated that the statistics suggest that diversion is a function of inpatient bed capacity. And further, he said, "The problem will probably get worse." However, he noted that for Region 4, the February data shows a drop from 2001 to 2002. For the first time, a drop in Region 3 from 2001 to 2002. It doubled from 1998 to 1999, up dramatically and then suddenly it is lower. This data has been taken from the EMS Regions (collected from hospitals). Data from the DPH's web site, in operation since 2001 shows over the long term, since October 2001, (i.e., diversion measured in proportion of total hospital time in the region in diversion). This data indicates 7.2% of time in diversion for Region 4 in this month. He noted that the improvement could be in more boarding of patients (i.e., patients registered but still in hallway awaiting a bed). To check this out, a DPH telephone survey was conducted. It was given to all Massachusetts Hospital Emergency Department Directors, asking them to compare this year's boarding with last years (on a five point scale): much worse, slightly worse, about the same, slightly better, much better, and we received responses from 62 of the 78 hospitals in Massachusetts with ERs. Five hospitals said that boarding was much worse than last year; Sixteen, slightly worse: nineteen about the same; twelve, slightly better, ten much better. "The boarding is the same as last year," stated. Dr. Dreyer. "Therefore, the improvement in diversion is not a function of the fact that people are boarding. Hospitals are taking active steps to improve the diversion situation such as increasing capacity (i.e., new physical beds) or staffing previously unoccupied beds or using current beds more efficiently (i.e., cleaning the bed faster); to using variation in scheduling surgeries." Dr.Sterne added, "The length of stay of the patient would make a difference." Dr. Dreyer agreed. In addition, Ms.Ridley noted two other things hospitals are doing: doctors are making earlier rounds so the patient can be discharged sooner and adding ancillary facilities like laboratories to avoid unnecessary hospital days while awaiting a test result.

In conclusion, Dr. Dreyer said, "Our conclusions are that hours on diversion status have in fact stabilized and there is some indication that they may be declining. Boarding seems to be constant. Utilization is

constant or increasing. Our best conclusion is that the improvement in diversion status reflects real progress. However, the current levels of boarding and diversion remain certainly higher than they were in the late 1990s and there is still additional work that needs to be done. Discusssion followed by the Council Members. Dr. Sterne summed up the discussion by stating, "…The two bottlenecks are the intensive care area after surgery or in a medical case, the medical ICU, and that drip down effect of getting those people out of those areas, down to a standard floor, and then out of that floor to a recuperating place outside of the hospital. If the outside world changes in the matter that makes the waiting time for rehab beds more difficult for people who are recuperating from serious illnesses, that will do exactly the opposite. It will hold people in a regular hospital bed in the ICU. There will be no place to send somebody out of an ICU to and so the prediction about the future is that critical are the external requirements for the hospital and the funding arrangements for payment for rehabilitation services."

Chairwomen Ferguson, Commissioner, Dept. of Public Health, added, "It would be fair to say that there have been some improvements made in this diversion issue but that the capacity of our hospitals and our delivery system to deal with acute situations, particularly in the Boston area is still very fragile, and that our ability as a State to work with the hospitals on these issues is going to become increasingly important as we go forward in the next couple of years. I think staff has done a phenomenal job in trying to pull together both long term data and some quick surveys to be able to point out what the trends are, but this is something that we need to keep a very close eye on, and work collaboratively with hospitals on, so that we don't find ourselves in a situation that is not tenable…."

**PROPOSED REGULATION: INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 430.000: MINIMUM SANITATION AND SAFETY STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN, STATE SANITARY CODE, CHAPTER IV:**

Mr. Howard Wensley, Director, Division of Community Sanitation, accompanied by Attorney Tracy Miller, Deputy General Counsel, Dept. of Public Health, presented the regulations to the Council. He said in part, "…Just to bring you up to date and give you a little bit of history relative to the Department's responsibility on recreational camps, the Department has been mandated to promulgate regulations on recreational camps for children since the early 1960s. The original regulations just dealt with stuff such as food service, space, sewage disposal and water. However, we have come a long way since then, and have recognized that the operation of a recreational camp involves a lot more than that. It includes staffing, staff qualification, programmatic uses and the regulations have expanded to include all of those particular issues….We are proposing a new amendment to the regulations, primarily the most important ones are dealing with updating the immunization requirements for campers. The previous regulations has content, or phased in regulations. The phase in time has changed or has come to completion, and they are looking at this particular time to eliminate the specific time language, or phase in language that is no longer applicable. At the request of the immunization staff of the Department, we are suggesting that the current requirement, the tetanus booster that has been given every ten years to staff less than 18 years of age be changed to requiring the booster every five years for

anybody entering grade 7 and above. A couple of other proposed changes are: that any bathing beaches used by camps comply with the State Sanitary Code dealing with bathing beaches; that any stables for horses maintained by the camp must be in facilities licensed by the Local Board of Health, and we are also proposing to eliminate any specific language about the egresses from sleeping cabins in recreational camps because this language overlaps and is handled primarily by the local building inspector, State Building Codes. We are anticipating that we will have public hearings on this in mid-April. Hopefully, we will be back to the Council for final promulgation in May." Several Council Members inquired about the standard of patient care in regards to the Tetanus Vaccine recommendation – why every five years instead of the universally accepted 10 years?" Mr. Wensley agreed to have the answer when he returns to the Council for final action. **NO VOTE/INFORMATION ONLY**

**EMERGENCY REGULATION: REQUEST FOR APPROVAL OF EMERGENY AMENDMENTS TO 105 CMR 430.000: MINIMUM SANITATION AND SAFETY STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN, STATE SANITARY CODE, CHAPTER IV:**

Mr. Howard Wensley, Director, Division of Community Sanitation, accompanied by Attorney Tracy Miller, Deputy General Counsel, Dept. of Public Health, presented the Emergency regulations to the Council for approval. He said in part, "…The Legislature passed and Governor Swift signed a new statute dealing with the requirements for background checks of any staff and volunteers at recreational camps for children. The regulations that we had on the books, that were strictly regulatory and were not backed up by statute, required that anyone with unsupervised contact in a recreational camp was required to pass certain background checks, which included the CORI, the Criminal History Systems Background Check, as well as the Sex Offender Registry. The statute, as was passed, requires the following:

430.090: Employment Information

This provision of the regulation is amended to comply with the requirements of the newly enacted statute, referenced above. As amended, this regulation requires that written procedures be developed and followed for the conduct of specific background checks for all staff and volunteers, not just those "who may have unsupervised contact" with campers. The amended regulations will require criminal background checks on all employees and volunteers, including those under the age of 17, regardless of whether they may have unsupervised contact with children. The statute and amended regulations will give camp operators access to a broader spectrum of CORI information including juvenile data.

The amendment to this regulation also requires in accordance with the statute that no staff person is allowed to work or volunteer at a recreational camp until the operator 'receives' the required background information. The regulations as amended will require this background information not only to be received, but also to be reviewed prior to an employee or volunteer commencing service. The current regulation allows individuals to be hired and to work with campers, prior to the required

background check, provided that they are directly supervised by a person whose background has been fully reviewed and found by the camp operator to be appropriate.

"The other issue",added Mr. Wensley, " is a change in the last page of Appendix A, Paragraph D, Subsection 2, it reads, 'A sex offender registry information check from the Massachusetts Sex Offenders Board for all prospective staff'. The last three words are redundant and are not needed.so delete for 'all prospective staff'."

In closing, staff stated, "The Public Health Council is respectfully requested to adopt the attached amendments to 105 CMR 430.000 as emergency regulations. Promulgation on an emergency basis is necessary in order to assure that recreational camps for children are compliant with the requirements of Chapter 385 of the Acts of 2002 for the 2003 camping season. The statute becomes effective on February 25, 2003, and preparation for the 2003 camping season by the camps is already underway. The Department is working with the Massachusetts Criminal History Systems Board (CHSB) in an effort to facilitate compliance with the new background check requirements. The statutory changes will require that camps be reauthorized by the CHSB in order to receive the additional information now mandated. To insure that this process is timely completed, it is essential that the regulations be effectuated as soon as possible."

After consideration, upon motion made and duly seconded, it was voted: (unanimously) to approve the **Emergency Amendments to 105 CMR 430.000: Minimum Sanitation and Safety Standards for Recreational Camps for Children, State Sanitary Code, Chapter IV;** that a copy be forwarded to the Secretary of the Commonwealth for promulgation; and that a copy be attached and made a part of this record as **Exhibit No. 14,752.** These amendments will be effective for 90 days, during which time a public hearing will be held to receive comments and staff will return to the Public Health Council for approval of the final regulations.

**DETERMINATION OF NEED PROGRAM:**

**COMPLIANCE MEMORANDUM: PREVIOUSLY APPROVED DoN PROJECT NO. 4-3951 OF CARITAS SOUTHWOOD HOSPITAL AND PROJECT NO. 4-3952 OF CARITAS NORWOOD HOSPITAL – PROGRESS REPORT ON COMPLIANCE WITH CONDITIONS OF APPROVAL FOR TRANSFER OF OWNERSHIP:**

Ms. Joyce James, Program Director, Determination of Need Program, presented the Compliance Memorandum on DoN Projects No. 4-3951 and 4-3952 to the Council. Ms. James said, "We are presenting to you today, staff's fifth annual progress report on compliance of conditions relating to transfer of ownership of Caritas Norwood Hospital and Caritas Southwood Hospital. These conditions cover seven areas, including statutory free care, voluntary free care, governance, mental health services, staffing, and landfill. The conditions also directed staff to report on the status of compliance to the Council after consultation with Caritas Norwood and Neponset Valley Community Health Coalition (the "Coalition"). With this report today, staff finds that the hospitals are in full compliance with all seven conditions of the approval. Therefore, we recommend that they should not be required to submit any

more progress reports on conditions relating to Project No. 4-3951 and 4-3952. This recommendation is consistent with the recommendation of the Coalition.

In conclusion staff reiterated, "Staff finds Caritas Norwood has achieved full compliance with the conditions relating to mental health services, adequate staffing levels, and remediation of the Southwood Community Hospital Site. With this finding, Caritas Norwood is now in full compliance with all the conditions of approval of Projects No. 4-3951 and 4-3952. These conditions relate to statutory and voluntary free care, governance, mental health services, staffing and landfill. Staff also finds that both Caritas Norwood and the Coalition must be commended for their efforts and commitment to work collaboratively to achieve full compliance of these conditions, which ultimately benefits the residents of the communities served by the Hospital. Staff must also recognize the Coalition's undeniable commitment to the communities it represents." Staff further noted for the record, on behalf of the Coalition:

"The Coalition would like to state for the record it has established a strong and effective working relationship with Caritas Norwood Hospital, and that the hospital, including the Chief Executive Officer and staff, is very attentive to the communities' needs and will always meet with the Coalition if so requested. The Coalition also thanks the Public Health Council for their oversight on these matters, and urge that it continue to get involved as communities in Massachusetts struggle to maintain essential hospital services."

After consideration, upon motion made and duly seconded, it was voted (unanimously) to accept staff's recommendation that **Caritas Norwood Hospital has achieved full compliance with all conditions of approval relating to Projects No. 4-3951 and 4-3952**. The Hospital should no longer be required to submit progress reports on these conditions.

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The meeting adjourned at 11:00 a.m.

LMH/lh

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Christine C. Ferguson, Chair
Public Health Council